

BEFORE THE DEPARTMENT OF INSURANCE  
STATE OF NEBRASKA

JAN 10 2005

FILED

STATE OF NEBRASKA  
DEPARTMENT OF INSURANCE,

PETITIONER,

VS.

UNITED HEALTHCARE INSURANCE  
COMPANY,

RESPONDENT.

CONSENT ORDER

CAUSE NO. C-1456

Jan 12, 2005 ACCT# 8521 \$62,500.00  
NO-INVOICE 74050 TRAN# 1397841  
UNITED HEALTHCARE INSURANCE COMPANY  
CHECK# 90005088

In order to resolve this matter, the Nebraska Department of Insurance ("Department"), by and through its representative, Martin W. Swanson and United Healthcare Insurance Company, ("Respondent"), mutually stipulate and agree as follows:

JURISDICTION

1. The Department has jurisdiction over the subject matter and Respondent pursuant to Neb. Rev. Stat. §44-101.01, §44-303 and §44-4047, et seq.
2. Respondent was licensed as an insurance company under the laws of Nebraska at all times material hereto.

STIPULATIONS OF FACT

1. The Department initiated this administrative proceeding by filing a petition styled State of Nebraska Department of Insurance vs. United Healthcare Insurance Company, Cause Number C-1456 on September 15, 2004. A copy of the petition was served upon the Respondent, at the Respondent's address registered with the Department by certified mail, return receipt requested.

2. The petition alleges that Respondent violated Neb. Rev. Stat. §§44-1540 (1), 44-1540(3), 44-1540(4), 44-1540(8), 44-1540(13), 44-1539 and Title 210, Chapter 61 §008.03, as a result of the following conduct in the following Consumer Affairs Investigation cases  
In Consumer Affairs Investigation number 04-0388:

- a. On August 25, 2003, Rosanna Moore's (Moore) daughter, Gabriella M. Moore (Gabriella), underwent extensive dental surgery. Gabriella's date of birth is June 7, 1999 and, at the time of surgery, Gabriella was 4 years old.
- b. The surgery was performed by Dr. Cade Hunzeker, Gabriella's dental provider. Dr. Hunzeker provided Moore with documentation confirming that general anesthesia was necessary. Dr. Hunzeker also confirmed through Respondent that the general anesthesia would be covered by Respondent. This assurance was based upon the Dr. Hunzeker's pre-authorization inquiry. Dr. Hunzeker was paid by Moore for the dental services rendered on or about the time between August 25, 2003 and October 24, 2003.
- c. The dental procedure was performed at the Omaha Surgical Center on or about August 25, 2003. Moore's husband, Elliott Moore (Elliott) made a \$1000 payment to meet the medical policy requirements. At that time, there was a balance due to the Omaha Surgical Center for \$950 for anesthesia.
- d. On September 8, 2003, Respondent acknowledged that it received the claim and denied it because additional insurance information was needed. However, a completed questionnaire from Moore was received by Respondent on August 23, 2003 which indicated that Gabriella did not have any other insurance coverage. On October 14, 2003, Respondent's records were updated reflecting this information and the claims were reprocessed.
- e. On October 3, 2003, Moore contacted Respondent and spoke to a supervisor by the name of "Laureen" who informed Moore that the anesthesia used in Gabriella's surgery would be covered due to the state mandate, specifically, Neb. Rev. Stat. §44-798.
- f. On October 30, 2003, Moore contacted Dr. Hunzeker's office requesting documentation for the anesthesia's authorization.
- g. On or about October 30, 2003, the claim was once again denied automatically by Respondent.

- h. On or about October 30, 2003, Respondent's internal notes and logs indicated that it recognized that the claim needed to be paid per Neb. Rev. Stat. §44-798 and that the claim needed to be reprocessed.
- i. On November 4, 2003, Respondent's internal notes revealed that Respondent's computer system automatically denied the claim and that the system needed to be examined.
- j. On December 17, 2003, Respondent's internal documents denoted that this matter was "urgent" and the internal notes further stated that the claim needed to be reprocessed in accordance with Neb. Rev. Stat. §44-798.
- k. On February 10, 2004, Moore contacted Respondent and spoke to a supervisor who told her that the "last processing" was on January 1, 2004 and that the matter was at the claims department. Respondent informed Moore that the claim was being denied because it should have been processed under the Moore's dental policy. Moore explained to Respondent that the dental services were paid in full and that the claim was for the anesthesia only. Respondent acknowledged that the anesthesia was covered under a Nebraska mandate, specifically, Neb. Rev. Stat. §44-798 and forwarded the claim. Respondent claimed that it would reprocess the claim once again. The claim was flagged again but Respondent did not process it correctly.
- l. On February 13, 2004, the claim was reprocessed by Respondent and automatically denied once again despite the "red flag" and the mandate. Respondent subsequently claimed that "At that time it was determined the diagnosis code submitted on the claims is considered dental, causing the system to recognize the claim as dental and deny it upon entry." Additionally, the claim was resubmitted by the Surgical Center on or about February 5, 2004, but it was processed under the incorrect number and denied for being past the filing limit time limit.
- m. On February 23, 2004, Moore contacted Respondent again and was told the claim was being denied for time limitations.
- n. On March 1, 2004, Respondent received another request to process the claims and they did so manually. In response to an April 6, 2004 letter from Barbara Ems (Ems), Consumer Affairs Investigator with the Nebraska Department of Insurance, Respondent claimed in a letter to Ems dated May 18, 2004, that the claim was not manually processed in October 2003 because the original request was misrouted to the incorrect area. Respondent further claimed that this issue was closed in error.

- DEC 10 2004 11:31AM THE DEPT OF INSURANCE NO. 321 P. 30
- o. In that letter of May 18, 2004, Respondent claimed that they "...*have not experienced similar issues as they may relate to this mandate.*" as described above in paragraph number 3 a – o. (Emphasis added).

In Consumer Affairs case number 03-1468:

- a. On February 21, 2003, John Gaukel's (Gaukel) daughter, Hsiang Ju J Chen (Chen), who was at the time less than eight years old, was hospitalized in order to receive dental care under general anesthesia.
- b. On April 1, 2003, Respondent denied the initial claim for Chen's services. On May 19, 2003, Gaukel contacted Respondent about the claim.
- c. On May 20, 2003, Respondent's internal records reveal that Respondent realized that a state mandate existed and places a note on the file that the claim needs to be adjusted. Despite this note, the claim was again denied on June 4, 2003. On June 5, 2003 Respondent asserted that the claim was processed correctly despite the fact that the mandate, namely Neb. Rev. Stat. §44-798, has been in effect since 2000.
- d. On or about June 5, 2003, Respondent once again acknowledged that a problem existed in their claim processing. During that time frame, Respondent, according to their internal notes, determined that they should be able to process the claim, however, on June 10, 2003 the claim was denied again.
- e. On or about June 21 or June 22 of 2003, Respondent's internal notes recognized that a problem existed in their system and that Respondent's system will continue to deny this claim if the system is not altered. On or about June 21, 2003, Gaukel called Respondent and threatened legal action. Once again, on June 21, 2003, Respondent's internal notes revealed that the state mandate is in place and the claim must be paid. However, on that same day, the claim was denied again.
- f. On June 31, 2003, Respondent decided that an exception form was needed to correct the issue of the denied claim. On August 4, 2003, Respondent sent in an internal request to perform a contract exception form. On August 8, 2003, Respondent cancelled that since a state mandate was at issue, a contract exception form was not necessary. Finally, the claim was processed via manual processing on August 26, 2003.
- g. On September 9, 2003, Respondent received an appeal request from Gaukel requesting a reconsideration of the denial of coverage for the dental services for Chen. The appeals coordinator reviewed all information submitted by Gaukel along with the certificate of coverage and concluded that the services

performed were denied in error. At that time, an adjustment request was sent to reprocess and pay for the services rendered. A letter to that effect was mailed to Gaukel on September 17, 2003.

- h. Jane Francis, (Francis) Administrator of the Consumer Affairs Division of the Nebraska Department of Insurance, initiated an investigation of this matter. Pursuant to that investigation, she exchanged in a series of letters with Respondent. In a November 17, 2003, letter, Francis asked why the claim was not paid until September when Respondent was aware of the state mandate in May and the claim payment was delayed for four months. Kimberly Wolff (Wolff), appeals coordinator with Respondent, replied on November 24, 2003. In response to that question, Respondent asserted "the claim required a manual adjustment in order to be reprocessed. It could not clear the Automated Review."
- i. Francis also asked in her November 17, 2003 letter whether or not the company conducted an audit of similar claims submitted by Nebraska residents to ensure that mandated coverage be provided for children under the age of 8. Respondent stated the following in their November 24, 2003 response:

"I posed this question to James Watson, UnitedHealthcare Compliance Director, who has advised that there is no need for an audit at this time. The claim originally denied 068 "not covered." The services are not covered unless the person is less than 8 years of age or mentally disabled. The claim system will deny the charges unless someone manually adjusts the claim to pay. *This is an isolated incident where the claim needed to be manually processed for benefits.*" (Emphasis Added).

In Consumer Affairs case number 04-1098:

- a. Three year old Nathan Sailors (Nathan), had to undergo dental surgery on November 10, 2003. As part of that surgery, anesthesia was necessary. The surgery was to be performed at the Omaha Surgical Center. Nathan's dentist, Dr. Cade Hunzeker, had his office contact Respondent to get preauthorization for the surgery. This contact was made on or about November 5<sup>th</sup> of 2003 both via letter and phone. Respondent claimed that the preauthorization for medical necessity of the surgery was not needed because of the state mandate, namely, Neb. Rev. Stat. §44-798. A letter was still sent to Respondent by Dr. Hunzeker's office even though Respondent stated that they do not enter the letter into the system because of the mandate. Nathan's mother, Katie (Katie) and his father (Nick) agreed to ahead with the procedure.

- b. On November 6, 2003, Respondent's internal notes revealed that it recognized and verified that dental anesthesia is covered for persons under the age of eight.
- c. On December 1, 2003, Respondent denied the claim.
- d. Respondent again denied Nathan's claim on December 4, 2003. Katie was told to submit the claims to her dental carrier.
- e. On December 30, 2003, Katie contacted Respondent. Additionally, contact was made between Dr. Hunzeker's office and Respondent. Respondent told Dr. Hunzeker's office that the claim should not have been denied because of Neb. Rev. Stat. §44-798. Respondent also told the Doctor's office that the claim would be researched. Eventually, one claim for the anesthesia was reprocessed and paid on January 23, 2004. Respondent informed Katie that the claim was still being researched but \$150 and \$400 were being sent to cover the anesthesia. The other claim for hospitalization, also based upon Neb. Rev. Stat. §44-798, was not paid at that time.
- f. On January 30, 2004, Katie contacted Respondent and was told that the Omaha Surgical Center needed to resubmit the claim using medical codes, not dental codes. The Omaha Surgical Center informed both Respondent and Katie that they never use dental codes but resubmitted the claim.
- g. From February 5, 2004 through April 20, 2004, the Sailors insurance policy changed to a different group number. Respondent, for reasons unknown, was processing the claim through their new group number and then subsequently denying the claim for lack of coverage. On April 20, 2004, Katie contacted Respondent. The problem was identified by Respondent and the claim was reprocessed under the old group number.
- h. Nathan's claim, was reprocessed under the old group number, was once again automatically denied by Respondent. According to Respondent, in a letter to the Nebraska Department of Insurance dated July 26, 2004, Respondent's processing system was setup to automatically deny dental claims because they are generally not covered under a member's medical benefits. Therefore, according to Respondent, claims that are payable need to be manually overridden in order to pay.
- i. On May 12, 2004, Katie contacted Respondent again and was told that the claim was submitted correctly on March 25, 2004 but was processed incorrectly by Respondent. Respondent tried to process it under the new group number even though the Omaha Surgical Center had the old group number on the submission. Respondent placed the old group number on the claim and told Katie to contact them in 7-10 days.

- j. On May 25, 2004, Katie contacted Respondent again. Respondent said that, for some reason, the \$1100 facility charge was not getting paid even though the mandate required payment. Another representative of Respondent apologized over and over, according to Katie, for the inconvenience and admitted that the claim should have been paid "months ago." Respondent stated, according to Katie, that their system automatically kicked the claim out because it was dental. Respondent agreed to send it to a technical analyst and it would be taken care of by Respondent.
- k. The claim was then sent to a technical analyst for review and the claim was reprocessed and, once again, denied by the system.
- l. On June 14, 2004, Katie contacted Respondent again about the claim. Respondent informed Katie that the claim never got sent to a technical analyst, despite previous claims by Respondent in earlier phone calls that it would be done. Respondent stamped an "urgent" notation on the claim, and reprocessed the claim. Respondent denied the claim again.
- m. On June 28, 2004, Katie contacted Respondent again. Respondent told her that the matter was sent to a technical analyst on June 14, 2004, however, Respondent closed the matter on June 16, 2004. During that phone call, Respondent told Katie that the statute, specifically, Neb. Rev. Stat. §44-798, applied only for anesthesia benefits and not hospital benefits. Respondent read Respondent's "version" of the statute to Katie and told Katie that she needed to file an appeal. Katie, instead, contacted Dr. Hunzeker's office who advised her to contact the Department of Insurance. Katie did contact the Nebraska Department of Insurance and filed a complaint on July 2, 2004.
- n. According to Respondent, on or around June 28, 2004, an urgent request was sent by Respondent to the technical analyst. At this time, the claim was adjusted for payment. On July 9, 2004, a check in the amount of \$950.00 was sent to the Omaha Surgical Center.
- o. Pursuant to the investigation, Respondent sent a letter to the Department of Insurance on July 26, 2004, wherein they admitted that there was a delay in processing the claim.
- p. On July 28, 2004, Barbara Ems, (Ems), a consumer affairs investigator with the Nebraska Department of Insurance, wrote Respondent and asked Respondent why both claims were denied especially considering that Neb. Rev. Stat. §44-798 had been discussed several times with Respondent because of previous complaints. Additionally, Ems questioned why Respondent took so long to pay either claim.

- q. On August 19, 2004, Respondent responded to Ems' July 28, 2004 letter and asserted that a "systems correction was performed on June 25, 2004 to allow for payment for claims that should be payable per LB 1253. The claims were processed before this correction was made, causing them to deny. Because the claims have been paid and our system corrected, we feel we are in compliance with LB 1253."

3. Respondent was informed of the right to a public hearing. Respondent waives that right, and enters into this Consent Order freely and voluntarily. Respondent understands and acknowledges that by waiving its right to a public hearing, Respondent also waives its right to confrontation of witnesses, production of evidence, and judicial review.

4. Respondent admits the factual allegations contained in the Petition and restated in Paragraph #2 above. However, Respondent does not admit to a violation of law and maintains the existence of a violation is in dispute.

#### CONCLUSIONS OF LAW


The conduct of United Healthcare Insurance Company, as alleged above, constitutes a violations of Neb. Rev. Stat. §§44-1540 (1), 44-1540(3), 44-1540(4), 44-1540(8), 44-1540(13), 44-1539 and Title 210, Chapter 61 §008.03.

#### CONSENT ORDER


It is therefore ordered by the Director of Insurance and agreed to by Respondent, that Respondent shall pay an administrative fine in the amount of \$62,500. The Respondent has thirty days from the date of approval of this consent order by the Nebraska Director of Insurance to pay the \$62,500 fine. Respondent shall, as a part of this consent order, address and fix any and all problems relating to processing claims under Neb. Rev. Stat. §44-798 within 30 days. Respondent shall provide proof to the Petitioner that the problem has been rectified. If said problem arises again after the assurances have been made to the Department, Respondent shall automatically be

subject to a \$100,000 fine and their certification of authority may be either revoked or suspended. The Nebraska Department of Insurance shall retain jurisdiction of this matter for the purpose of enabling the Department to make application for such further orders as may be necessary.

In witness of their intention to be bound by this Consent Order, each party has executed this document by subscribing their signatures below.

  
Martin W. Swanson, #20795  
Department of Insurance  
941 "O" Street, Suite 400  
Lincoln, Nebraska 68508  
(402) 471-2201

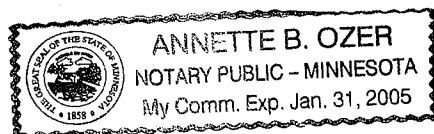
1/5/05  
Date


  
Mary Stanislav  
Counsel  
United Healthcare Inc.  
5901 Lincoln Drive  
Edina, MN 55436

12/15/04  
Date

State of Minnesota )  
County of Hennepin ) ss.

On this 15<sup>th</sup> day of December, 2004, United Healthcare Insurance Company personally appeared before me and read this Consent Order, executed the same and acknowledged the same to be his voluntary act and deed.



  
Notary Public

**CERTIFICATE OF ADOPTION**

I hereby certify that the foregoing Consent Order is adopted as the Final Order of the  
Nebraska Department of Insurance in the matter of State of Nebraska Department of Insurance vs.  
United Healthcare Insurance Company, Cause No. C-1456.

STATE OF NEBRASKA  
DEPARTMENT OF INSURANCE



L. TIM WAGNER  
Director of Insurance

1/10/05

Date

**CERTIFICATE OF SERVICE**

I hereby certify that a copy of the executed Consent Order was sent to the Respondent at  
Mail Stop MN 012-S205, 5901 Lincoln Drive, Edina, MN 55436, by certified mail, return receipt  
requested on this 3<sup>rd</sup> day of January, 200~~4~~<sup>5</sup>

